

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175499</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/11/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRIGHTON GARDENS OF PRAIRIE VILLAGE</b> |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7105 MISSION ROAD</b><br><b>PRAIRIE VILLAGE, KS 66208</b>                    |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE   |
| F 000  | INITIAL COMMENTS   | F 000  |  |  |  |
| F 312<br>SS=D  | <p>The following citations represent the findings of complaint investigations #62393, and #66142</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>The facility identified a census of 28 residents. Based on observation, record review, and interview, the facility failed to provide dining assistance to 2 residents sampled (#1, and #2) and one unsampled resident (#4), and failed to provide repositioning assistance to one resident sampled (#2), and 2 unsampled residents (#4, and #5).</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Resident #1's Minimum Data Set (MDS) 3.0 annual assessment dated 5/7/13, identified the resident had long and short term memory problems, and required supervision with eating.</li> </ul> <p>The Care Area Assessment (CAA) for activities of daily living (ADL) dated 5/7/13 listed the resident continues to need total to extensive assist with functions that varied daily. Staff provided assistance with eating with the use of a built up spoon, he/she continued to need staff to help with finishing meals and fluids.</p> | F 312  |  |  |  |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |                            |  |
|--|---|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175499</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/11/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRIGHTON GARDENS OF PRAIRIE VILLAGE</b> |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7105 MISSION ROAD</b><br><b>PRAIRIE VILLAGE, KS 66208</b>                    |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
| F 312  | <p>Continued From page 1</p> <p>The careplan for nutrition dated 5/22/13 listed to use built up utensil and plate guard, allow the resident to eat as much of meal as he/she can independently and then assist with meals as he/she will allow.</p> <p>Staff took the resident to the dining room, at 12:30 P.M. on 5/30/13. Staff placed juice and salad in front of the resident. The resident did not initiate eating. Two staff sat at the table and talked among themselves about meatloaf, children and birthdays. Staff gave the resident a bite of salad at 12:40 P.M. The main meal arrived at 12:51 P.M.. Facility staff fed 3 residents who sat the table with resident #1. Resident #1 attempted to eat. The resident picked up his/her plate and was told by direct care staff A to put the plate down because he/she did not want him/her to spill the plate on the floor. The resident attempted to feed him/herself and direct care staff A asked the resident if he/she was playing with his/her peas. Staff did not assist the resident with the meal until approximately 1:05 P.M.</p> <p>Interview on 6/3/13 at 4:40 P.M. with administrative staff B and C revealed staff should be ready to assist the resident when the food arrived. We did not expect staff to speak among themselves when assisting the residents to eat. We have conducted inservices on this topic and would need to repeat them.</p> <p>The facility failed to assist the dependent resident to eat in a timely manner.</p> <p>- Resident #2's Minimum Data Set (MDS) 3.0 a significant change assessment dated 5/3/13</p> | F 312  |  |                            |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |   |  |  |                            |
|--|---|--|--|---|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175499</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                  |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/11/2013</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRIGHTON GARDENS OF PRAIRIE VILLAGE</b> |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7105 MISSION ROAD</b><br><b>PRAIRIE VILLAGE, KS 66208</b> |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  |  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
| F 312  | <p>Continued From page 2</p> <p>listed a Brief Interview for Mental Status (BIMs) score of 1 indicating severe cognitive impairment, and the resident required limited assistance of 1 staff member with eating.</p> <p>The Care Area Assessment (CAA) dated 5/3/13 for nutrition listed the resident was at risk for weight loss due to poor appetite, memory, anxiety, and agitation. The resident received help from staff and they encouraged him/her to be independent with feeding him/herself.</p> <p>The care plan for nutrition dated 5/3/13 listed the resident could feed him/herself some of his/her meal, but staff would usually have to help as he/she allowed. The staff encouraged and assisted the resident to eat all his/her food and fluids at meals, and offer extra if he/she would take it.</p> <p>Observation of resident in the dining room on 5/30/13 at 12:10 P.M. revealed the resident sat alone at the table with fruit and thickened water in front of the him/her. The resident took the fruit and spilled it on his/her lap, and spilled the thickened water on the table. At approximately 12:40 P.M. licensed staff D removed the fruit from the resident's lap, cleaned up the spilled water, and came back to feed the resident. The resident was fed a pureed lunch, of which he/she ate 5 to 10 % . The resident sat in his/her broda chair ( a specialized wheelchair) and leaned to the left. Staff D removed the resident from the dining room to the entrance by the door of the dining room. He/she remained in the broda chair and leaned to the left from 1:10P.M. to 1:25 P.M.. Staff D attempted to reposition the resident unsuccessfully. He/she remained leaning to the</p> |  |  | F 312   |  |  |                            |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |  |  |
|--|---|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175499</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/11/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRIGHTON GARDENS OF PRAIRIE VILLAGE</b> |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7105 MISSION ROAD</b><br><b>PRAIRIE VILLAGE, KS 66208</b>                    |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE   |
| F 312  | <p>Continued From page 3</p> <p>left until staff placed the resident in bed at 2:00 P.M. Observation revealed numerous facility staff walked by the resident and made no attempt to reposition him/her.</p> <p>Interview on 6/3/13 at 4:40 P.M. with administrative staff B and C. revealed when staff saw a resident leaning if in a broda chair they could tilt the back of the chair, to place the resident in a more comfortable position. Staff should address the problem.</p> <p>Interview on 6/3/13 at 4:40 P.M. with administrative staff B and C. revealed staff should be there and ready to assist the resident when the food arrived.</p> <p>Review of the facility policy for positioning dated 2007 listed for positioning in the chair. Reposition the resident every 2 hours or more often, according to the plan of care, move the resident and change the points of pressure, wash hands. The policy did not address repositioning the resident who was leaning.</p> <p>The facility failed to offer timely cueing and dining assistance for this cognitively impaired dependnet resident, and failed to reposition the resident in the broda chair.</p> <p>- Observation on 5/30/13 at 12:10 P.M. of unsampled resident #4 revealed the resident sat with his/her back to the dining room with pureed soup and thickened water and juice. The resident remained unassisted with dining. The resident sat in a high backed wheelchair with his/her head on his/her chest drooling, and leaning forward. At 12:41 P.M. licensed staff D assisted the resident</p> | F 312  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |                            |  |
|--|---|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175499</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/11/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRIGHTON GARDENS OF PRAIRIE VILLAGE</b> |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7105 MISSION ROAD</b><br><b>PRAIRIE VILLAGE, KS 66208</b>                    |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
| F 312  | <p>Continued From page 4</p> <p>to eat. Staff did not reposition the resident prior to feeding, the resident continued to lean forward as staff assisted the resident.</p> <p>Review of the facility policy for positioning dated 2007 listed for positioning in the chair, to reposition the resident every 2 hours or more often, according to the plan of care. Move the resident and change the points of pressure. The policy did not address repositioning the resident who was leaning.</p> <p>Interview on 6/3/13 at 4:40 P.M. with administrative staff B and C staff should be ready to assist the resident when the food arrived. Resident #4 had a feeding assistant for breakfast, and his/her family member came in to assist him/her with dinner. Facility staff were responsible to assist the resident lunch.</p> <p>The facility failed provide dining and repositioning assistance for this dependent resident.</p> <p>- Unsampled resident #5 on 5/30/13 at 3:57 P.M. sat in activity the room with staff, leaning to the right, with his/her head almost to his/her knees.</p> <p>On 5/30/13 at 4:15 P.M. the resident sat in his/her broda chair( specialized wheelchair) in front of the nurses station with his/her head down, leaning slightly forward and drooling. Facility staff walked by the resident in the hall and failed to reposition the resident.</p> <p>Interview on 6/3/13 at 4:40 P.M. with administrative staff B and C revealed when staff saw a resident leaning, they should place the resident in a more comfortable position. Staff</p> | F 312  |  |                            |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |  |  |
|--|---|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175499</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/11/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRIGHTON GARDENS OF PRAIRIE VILLAGE</b> |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7105 MISSION ROAD</b><br><b>PRAIRIE VILLAGE, KS 66208</b>                    |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE   |
| F 312  | Continued From page 5<br>should address the problem.<br><br>Review of the facility policy for positioning dated 2007 listed for positioning in the chair. Reposition the resident every 2 hours or more often, according to the plan of care, and move the resident and change the points of pressure. The policy did not address repositioning of the resident who was leaning.<br><br>The facility failed to provide repositioning assistance for this dependent resident.  | F 312  |  |  |  |
| F 315<br>SS=D  | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 28 residents. The sample size included Based on observation, record review, and staff interview, the facility failed to provide timely toileting for 3 of 3 residents sampled. (#1, #2, #3.)<br><br>Findings included:<br><br>- Resident #1 Minimum Data Set (MDS) 3.0 | F 315  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |  |  |
|--|---|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175499</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/11/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRIGHTON GARDENS OF PRAIRIE VILLAGE</b> |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7105 MISSION ROAD</b><br><b>PRAIRIE VILLAGE, KS 66208</b>                    |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE   |
| F 315  | <p>Continued From page 6</p> <p>annual assessment dated 5/7/13, listed long and short term memory problems. The resident was incontinent of bowel and bladder (B&amp;B), was totally dependent on 1 staff for toilet use, and personal hygiene, and no toileting program in place.</p> <p>The Care Area Assessment (CAA) for activities of daily living (ADLs) dated 5/7/13 listed the resident continued to need total to extensive assist, functions vary daily, and staff provided toileting assistance, pericare, and clothing changes.</p> <p>The Care Area Assessment (CAA) for incontinence dated 5/13/13 listed the resident as incontinent of B&amp;B, he/she did not make staff aware of the need to toilet. Staff checked and changed the resident, and provided peri-care and clothing changes. Staff observed and reported signs and symptoms of urinary tract infections to hospice.</p> <p>The care plan dated 5/22/13 for continence listed the resident required extensive assist of 1-2 staff with toileting, transfers, clothing management and pericare. Staff offered to take the resident to the toilet and provide peri-care upon rising, before and after meals, and as needed (prn), during the night prn. The resident wore incontinence products.</p> <p>On 5/30/13 at 12:10 P.M. direct care staff A toileted the resident. Staff assisted the resident onto the toilet. The resident's jeans were wet in the pubic area. The resident voided and had a</p> | F 315  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |                            |  |
|--|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175499</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/11/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRIGHTON GARDENS OF PRAIRIE VILLAGE</b> |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7105 MISSION ROAD</b><br><b>PRAIRIE VILLAGE, KS 66208</b>                    |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
| F 315  | <p>Continued From page 7</p> <p>bowel movement (BM) while seated on the toilet. Staff provided peri-care, redressed the resident, transferred the resident from the toilet to the wheelchair, and wheeled the resident to the dining room.</p> <p>On 5/30/13 at 12:10 P.M. direct care staff A stated the resident would tell you when he/she needed to use the toilet to have a BM. Residents would be checked every 2 hours and as needed to see if they were wet or soiled.</p> <p>Observation on 5/30/13 from 12:10 P.M. to 1:30 P.M. the resident sat in the dining room at the noon meal.</p> <p>Observation on 5/30/13 from 1:30 P.M. to 3:30 P.M. the resident sat in his/her wheelchair in the activity room, no toileting offered.</p> <p>Observation on 5/30/13 from 3:45 P.M. to 4:50 P.M. the resident continued to sit in the activity room no toileting offered.</p> <p>Observation on 5/30/13 at 4:50 P.M. direct care staff E took the resident to his/her room to toilet the resident. Direct care staff F assisted with the transfer of the resident to the toilet, and removed the resident's brief. The brief was saturated with a medium to moderate amount of urine per facility staff F. Direct care staff E revealed at that time, he/she did not receive information regarding the last time the day shift toileted the resident. He/she was told the resident was in the activity room, and would be ready after the other residents.</p> | F 315  |  |                            |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |                            |  |
|--|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175499</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/11/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRIGHTON GARDENS OF PRAIRIE VILLAGE</b> |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7105 MISSION ROAD</b><br><b>PRAIRIE VILLAGE, KS 66208</b>                    |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
| F 315  | <p>Continued From page 8</p> <p>On 6/3/13 at 4:40 P.M. administrative staff B and C stated residents should be checked for incontinence, when staff got the resident up in the morning, before and after meals, at bedtime, and as needed.</p> <p>The facility provided a policy for incontinent/perineal care not dated that listed it was the policy of this facility that incontinent care was provided at a minimum of every 2 hours and immediately after episodes of incontinence.</p> <p>The facility failed to provide timely incontinent care for this resident who required staff assistance and monitoring.</p> <p>- Resident #2 Minimum Data Set (MDS)3.0 a significant change assessment dated 5/3/13 listed a Brief Interview for Mental Status (BIMs) score of 1 indicating severe cognitive impairment. The resident required total assistance of 1 staff member with toilet use.</p> <p>Care Area Assessment (CAA) dated 5/8/13 for urinary incontinence listed the resident was incontinent frequently to totally at times. Staff would check and change the resident when he/she got up, at bedtime, before /after meals and as needed (prn) thru out the day, and every 2 hours at night. He/she could become abusive to staff and staff not able to redirect him/her for cares. The resident wore continence products provided by hospice. The staff provide peri-care and clothing management. Staff would notify the nurse and hospice of any change in skin condition.</p> | F 315  |  |                            |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |                            |  |
|--|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175499</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/11/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRIGHTON GARDENS OF PRAIRIE VILLAGE</b> |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7105 MISSION ROAD</b><br><b>PRAIRIE VILLAGE, KS 66208</b>                    |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
| F 315  | <p>Continued From page 9</p> <p>The care plan for incontinence dated 5/3/13 listed the resident was incontinent of B&amp;B (bowel and bladder). Hospice provided briefs to wick moisture away and for dignity. The staff would check and change the residents brief, provide peri-care upon rising, bedtime, before and after meals and prn. Resident required assistance with toileting and personal hygiene. Staff would observe and report signs and symptoms of urinary tract infection to hospice, and physician, 4/26/13 urine sample (U/A) for urinary tract infection with negative result, encourage fluids with cares, and keep a cooler with thickened liquids in his/her room.</p> <p>Observation on 5/30/13 11:00A.M the resident sat in a broda chair in the hall. He/she flagged people down to talk to them.</p> <p>Observation on 5/30/13 at 11:30 A.M. staff wheeled the resident into the activity room.</p> <p>Observation of resident on 5/30/13 at 12:10 P.M. revealed the resident sat alone in the dining room at the table. Staff D removed the resident from the dining room to the entrance by the door of the dining room. At 1:10P.M. and remained there until 1:25 P.M.</p> <p>Observation of direct care staff G on 5/30/13 at 2:00 P.M. revealed the resident was wet and revealed he/she provided incontinence care and wore the same gloves to reposition the resident's</p> | F 315  |  |                            |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |                            |  |
|--|---|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175499</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/11/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRIGHTON GARDENS OF PRAIRIE VILLAGE</b> |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7105 MISSION ROAD</b><br><b>PRAIRIE VILLAGE, KS 66208</b>                    |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
| F 315  | <p>Continued From page 10</p> <p>shoulders, adjusted the blankets, and adjusted the bed controls. On interview staff G confirmed the resident was not checked or changed since this direct care staff got the resident up at approximately 8:00 A.M. this morning. Staff further confirmed he/she should have checked or changed the resident at approximately 10:00 A.M, this staff stated he/she should have removed his/her gloves and washed his/her hands prior to touching the resident, blankets, and bed controls.</p> <p>The facility provided a policy undated for incontinent/perineal care that listed it was the policy of this facility that incontinent care was provided at a minimum of every 2 hours and immediately after episodes of incontinence. After care was provided the policy directed staff to remove gloves, and wash hands, and return the resident to a clean comfortable position.</p> <p>Interview on 6/3/13 at 4:40 P.M. with administrative staff B and C revealed residents were checked for incontinence, when staff got the resident up in the morning, before and after meals, at bedtime, and as needed.</p> <p>The facility failed to provide timely incontinent care for this resident who required staff assistance and monitoring.</p> <p>- Resident #3's Minimum Data Set (MDS) 3.0 a significant change assessment dated 4/8/13 listed long and short term memory problems, and the resident required total assistance of 2 staff members with toilet use.</p> | F 315  |  |                            |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |                            |  |
|--|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175499</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/11/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRIGHTON GARDENS OF PRAIRIE VILLAGE</b> |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7105 MISSION ROAD</b><br><b>PRAIRIE VILLAGE, KS 66208</b>                    |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
| F 315  | <p>Continued From page 11</p> <p>The Care Area Assessment (CAA) for cognition dated 4/8/13 listed staff provided all cares for the resident with little or no effort from the resident. He/she was on hospice services since return to community.</p> <p>The CAA for urinary incontinence dated 4/8/13 listed to check and change the brief due to the resident was unaware and did not let staff know of his/her needs. Staff checked the residents brief when he/she got up and prior to bedtime, before and after meals and as needed (prn). When the resident was restless report any signs or symptoms of urinary tract infection, staff change the soiled brief, provide pericare, and notify the nurse of any skin issues. Fluids were encouraged with meals and with cares.</p> <p>The care plan dated 4/15/13 for bowel and bladder listed the resident incontinent of B&amp;B. The resident wore a brief to wick moisture away and for dignity. Staff checked the brief when getting the resident up, prior to bedtime, before and after meals, and prn. Apply barrier cream after pericare, notify the nurse and hospice of any skin issues, rash, redness, or open areas, and encourage intake of fluids when alert enough to swallow.</p> <p>On 5/30/13 at 10:57 A.M. the resident was laid in a low bed.</p> <p>At 11:49 A.M. on 5/30/13 the resident sat up in his/her broda chair(specialized wheelchair). Staff</p> | F 315  |  |                            |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |                            |  |
|--|---|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175499</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/11/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRIGHTON GARDENS OF PRAIRIE VILLAGE</b> |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7105 MISSION ROAD</b><br><b>PRAIRIE VILLAGE, KS 66208</b>                    |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
| F 315  | Continued From page 12<br>took the resident to the dining room for lunch. At 12:32 P.M. the resident ate with staff at the table assisting the resident as needed.<br><br>At 1:15 P.M. on 5/30/13 the resident was returned to his/her room and laid down by facility staff. Staff did not checked or provide incontinent care.<br><br>The resident he/she remained in bed from 1:15 P.M. to 4:35 P.M. on 5/30/13 at which time direct care staff I performed incontinent care for the resident. Staff confirmed the brief was saturated with urine. Interview with direct care staff I stated off going staff did not tell him/her when the resident was last checked or changed.<br><br>On 6/3/13 at 4:40 P.M. administrative staff B and C stated residents are to be checked for incontinence, when staff got the resident up in the morning, before and after meals, at bedtime, and as needed.<br><br>The facility failed to provide timely toileting for this resident who required staff assistance and monitoring. | F 315  |  |                            |  |
| F 323<br>SS=D  | 483.25(h) FREE OF ACCIDENT<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  | F 323  |  |                            |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |                            |  |
|--|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175499</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/11/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRIGHTON GARDENS OF PRAIRIE VILLAGE</b> |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7105 MISSION ROAD</b><br><b>PRAIRIE VILLAGE, KS 66208</b>                    |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
| F 323  | <p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by:<br/>The facility identified a census of 28 residents of which 3 were sampled. Based on observation, record review, and interview, the facility failed to provide supervision to prevent falls for 2 of 3 residents. (#1, and #3).</p> <p>Findings included :</p> <ul style="list-style-type: none"> <li>- Resident #1's Minimum Data Set (MDS)3.0 annual assessment dated 5/7/13, listed long and short term memory problems, the resident had a history of falls in the last 2 to 6 months and falls since the prior assessment.</li> </ul> <p>The Care Area Assessment (CAA) for falls dated 5/7/13 listed the resident was a very high risk for falls, and had a history of multiple falls. He/she had long and short term memory loss, needed assistance with transfers, activities of daily living (adls) were impulsive, reached out to lean over things, tried to pick up objects, and he/she crawled out of his/her bed. The resident received antianxiety and antidepressant medications for the diagnosis of depression, anxiety, end stage dementia, and parkinsons. Staff assisted with transfers, the resident had wheelchair (w/c) and bed alarms. Staff anticipated his/her needs, bed was kept in low position with a mat beside it due to the resident crawling out of his/her bed and safety. Staff redirected him/her away from his/her room when he/she was headed that way as the resident was not safe when in his/her room alone. Staff notified hospice of falls or decline in</p> | F 323  |  |                            |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |                            |  |
|--|---|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175499</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/11/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRIGHTON GARDENS OF PRAIRIE VILLAGE</b> |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7105 MISSION ROAD</b><br><b>PRAIRIE VILLAGE, KS 66208</b>                    |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
| F 323  | <p>Continued From page 14<br/>function.</p> <p>Care plan dated 5/22/13 listed the resident had a pressure reduction mattress on bed, with a bed that lowered, and a mat by it when he/she is in bed for safety. The resident attempted to ambulate independently and often will fall, so staff discourage ambulation on his/her own. Staff to offer to assist with ambulation daily, as he/she desired or you see him/her trying to ambulate. the resident required extensive assistance of 1 to 2 staff dependent on occupational therapy orders, bed and wheelchair (w/c) alarms in place to alert staff when he/she was trying to get up without asking for assistance, and to remind him/her of importance of asking for assistance, offer to use my walker to walk to meals, he/she often refuses to allow staff to ambulate with him/her after they had offered.</p> <p>The care plan for falls dated 5/22/13 listed the resident had no serious injuries from falls. 5/14/13 fell from bed to mat, intervention to reposition the bed alarm, 5/12/13 ordered to stop leg rests for high back w/c. Restarted Seroquel 1/2 tablet at bedtime, 5/22/13 fall in hall sustained laceration went to emergency room/returned would ask hospice for psychiatric evaluation and dycem (an anti slip material) for w/c, and conduct a medication review, assist with transfers and ambulation daily as he/she would allow, as he/she wanted to be independent, bed and w/c alarms in place to alert staff and to remind the resident to ask for assist prior to getting up, bed in low position when he/she is in it, and mat on floor when in bed. f offer to walk with the resident, encourage to attend activities while awake and up in w/c. Encourage not to be in his/her room</p> | F 323  |  |                            |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |                            |  |
|--|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175499</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/11/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRIGHTON GARDENS OF PRAIRIE VILLAGE</b> |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7105 MISSION ROAD</b><br><b>PRAIRIE VILLAGE, KS 66208</b>                    |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
| F 323  | <p>Continued From page 15</p> <p>alone, although he/she had this right and refused at times, and observe for side effects of medications.</p> <p>Nurses notes (NN) dated 4/15/13 at 6:19 A.M. stated at 4:58 A.M. staff found the resident on top of the floor mat next to his/her bed, the bed alarm sounded. The resident was alert and oriented to his/her self with increased confusion, appeared anxious, denied pain or discomfort, and as needed (prn) Ativan given. Staff notified the medical doctor, hospice, durable power of attorney (dpoa), and director of nursing services.</p> <p>A NN dated 4/19/13 staff found the resident on the floor by his/her chair. Range of motion (ROM) was within normal limits with no apparent injury, staff initiated neuro checks, assisted the resident back to the chair, and the staff would keep the resident in close vicinity of staff for close monitoring while in the chair.</p> <p>A NN dated 4/25/13 (late entry for 4/24/13) not timed revealed staff found the resident on the floor. Resident was observed climbing out of bed to the floor mat. Resident was assessed and vital signs taken. No injuries were noted. Resident was assisted back to his/her chair and out to the activity room. Family and doctor notified.</p> <p>NN 5/14/13 at 3:15 A.M. resident had non injury fall, care manager reported he/she was found sitting next to his/her bed, no injuries noted or c/o pain vitals blood pressure 88/56, temperature 97.6, pulse 63, oxygen saturation 96%.</p> <p>A NN dated 5/22/13 at 9:20 P.M. documented at 4:40 P.M. the resident sat in his/her w/c in lobby area. The resident attempted to stand up, and fell forward landing on his/her head. Range of motion (ROM) was within normal limits, pupils equal</p> | F 323  |  |                            |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |                            |  |
|--|---|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175499</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/11/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRIGHTON GARDENS OF PRAIRIE VILLAGE</b> |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7105 MISSION ROAD</b><br><b>PRAIRIE VILLAGE, KS 66208</b>                    |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
| F 323  | <p>Continued From page 16</p> <p>round reactive to light and accommodation. (PERRLA). No complaint of pain or discomfort voiced. Staff assisted the resident to the w/c. Resident noted to have abrasion to top of head and laceration to chin. Doctor family and administration notified. Emergency medical staff (EMS) notified to transfer resident to the emergency room (ER) for evaluation and treatment. The resident was sent to a local hospital where he/she received sutures to the chin. The resident returned to facility at 7:15 P.M. with orders to monitor chin for signs and symptoms of infection and to remove stitches in 5 days</p> <p>A NN dated 5/26/13 at 10:48 P.M. revealed staff found the resident sitting on the floor mat beside his/her bed with the alarm sounding. No apparent injury noted. Neuro checks initiated due to incident unobserved and the resident was assisted back into bed.</p> <p>Observation of the resident on 5/30/13 at 10:45 A.M. the resident sat in the common area in a high back wheelchair listening to big band music. His/her eyes were closed, but upper body was swaying back and forth.</p> <p>Observation on 5/30/13 at 12:10 P.M. staff toileted the resident. Staff provided peri care, redressed the resident, transferred the resident from the toilet to the wheelchair, and wheeled the resident to the dining room.</p> <p>An interview on 6/3/13 at 4:40 P.M. with administrative staff B and C. The resident's mental abilities fluctuate over the course of the day, one would not expect him/her to ask for assistance consistently or to remember not to get up on his/her own.</p> <p>The facility failed to provide adequate monitoring</p> | F 323  |  |                            |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |                            |  |
|--|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175499</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/11/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRIGHTON GARDENS OF PRAIRIE VILLAGE</b> |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7105 MISSION ROAD</b><br><b>PRAIRIE VILLAGE, KS 66208</b>                    |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
| F 323  | <p>Continued From page 17</p> <p>to prevent the resident from additional falls .</p> <ul style="list-style-type: none"> <li>- Resident #3's Minimum Data Set (MDS) 3.0 a significant change assessment dated 4/8/13 listed long and short term memory problems. Had a fall history, listed 2 falls in the last 2-6 month period, no fractures, and 2 non injury falls since admission.</li> </ul> <p>The Care Area Assessment (CAA) dated 4/8/13 for falls listed the resident had rolled off of his/her bed onto his/her mat. Hospice provided bolsters for the mattress. Staff check his/her brief when fidgety. When in bed, the bed was kept in the low position, with a mat beside it. Staff always transfer the resident using a 2 person transfer. The resident does not use his/her call light due to cognition, and was not able to make his/her needs known. Staff anticipate the residents needs. Hospice had provided him/her with a low air loss mattress and broda chair with a cushion.</p> <p>The care plan dated 4/15/13 for bed mobility listed Hospice had provided bed bolster for my loss air loss mattress. If I am fidgety while in bed check for incontinence. Broda chair with cushion in seat when out of bed. On 4/17/13 the resident fell out of his/her broda chair (specialized wheelchair )in his/her room, non injury noted with the intervention to not leave the resident alone in the broda chair in his/her room.</p> <p>The care plan dated 4/15/13 for falls listed the resident with a history of falls. He/she picked things up off the floor. The resident fell out of bed due to being restless and hopice provided bolsters to make him/her aware of perimemters of the bed. The bed was in the low position with a mat beside. Staff check the resident often when</p> | F 323  |  |                            |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |                            |  |
|--|---|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175499</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/11/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRIGHTON GARDENS OF PRAIRIE VILLAGE</b> |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7105 MISSION ROAD</b><br><b>PRAIRIE VILLAGE, KS 66208</b>                    |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
| F 323  | <p>Continued From page 18</p> <p>he/she was restless, and changes brief if needed. Reposition for comfort. Transfer the resident with assist of 2 due to impaired cognition catabolic state at times. Bed low with alarm in place to alert staff. When restless check for needs and assist as needed. If the resident was restless when he/she was up in the chair, lay him/her down comfortably for rest, in a quiet environment. Do not leave the resident in his/her room alone when up in the chair, check the alarm for proper function. 4/4/13 Reviewed the resident at risk meeting bolster was placed. clarified it was not a restraint.</p> <p>On 3/29/13 timed 8:13 P.M. the nurses note (NN) revealed the resident was found on floor by a family member with his/her head facing downward, staff assessed the resident with no injuries noted. The resident was agitated and as needed medication was administered. The physician, hospice, and director of nursing were notified.</p> <p>On 4/6/13 at 11:15 P.M. NN revealed staff found the resident lying on the floor mat. He/she was wet, after assessing there was no injury the resident was transferred to the bed and his/her brief was changed.</p> <p>On 4/24/13 at 4:15 P.M. NN revealed the staff found the resident on the floor by his/her bedside. Resident was assessed without apparent injury. Range of motion (ROM) was within normal limits. Resident noticed to grimace. Medication for pain administered as ordered. Resident currently sitting in broda chair, and appeared relaxed with eyes closed. Physician notified, family called</p> | F 323  |  |                            |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |                            |  |
|--|---|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175499</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/11/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRIGHTON GARDENS OF PRAIRIE VILLAGE</b> |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7105 MISSION ROAD</b><br><b>PRAIRIE VILLAGE, KS 66208</b>                    |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
| F 323  | <p>Continued From page 19</p> <p>neurological checks started, and a new order for Roxanol 0.5ml for pain, and Ativan 0.5 ml sublingual for restlessness.</p> <p>On 4/27/13 at 10:20 P.M. a NN revealed the resident fell in the activity room. The alert went off suddenly, as staff noticed him/her trying to get out of the broda chair, the resident fell out of the chair head first and by the time staff arrived the residents head was on the floor lying on the left side, with skin tear to the left eyebrow, and left forearm was bleeding. Staff would notify the family, director of nursing, hospice, and physician. Neurological checks were started, staff will continue to monitor.</p> <p>On 4/27/13 at 11:00 P.M. NN the bed alarm sounded, staff found the resident lying on the floor on the mat next to the bed awake and alert. No injuries were noted. Staff assisted the resident off the floor, no signs of pain noted. Neurological checks continued from previous fall, and no bleeding noted. This nurse checked the resident and bed alarm was in place, mat was on the floor. The resident was positioned for comfort, with the call light within reach. Staff notified the family, hospice and the physician on call.</p> <p>On 5/1/13 at 9:30 A.M. a NN the resident was observed by nurse, the resident was restless and anxious and in constant motion. The resident slid him/herself out of the broda chair and onto floor. No apparent injury, doctors office and husband notified.</p> <p>Observation of the resident on 5/30/13 at 10:57 A.M. The resident was in a low air loss bed with a</p> | F 323  |  |                            |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |                            |  |
|--|---|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175499</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/11/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BRIGHTON GARDENS OF PRAIRIE VILLAGE</b> |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7105 MISSION ROAD</b><br><b>PRAIRIE VILLAGE, KS 66208</b>                    |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
| F 323  | <p>Continued From page 20</p> <p>mat on the floor, lying on his/her back, the call light within reach.</p> <p>Observation of direct care staff on 5/30/13 at 11:20 A.M. provided perineal care to the resident, the call light was within the residents reach.</p> <p>At 11:49 AM on 5/30/13 the resident was up in his/her broda chair. Staff took the resident to the dining room for lunch.</p> <p>Observation of the resident in bed from 1:15 P.M. to 4:35 P.M. on 5/30/13.</p> <p>Interview on 6/3/13 at 4:40 P.M. with administrative staff B and C stated the resident would not be able to ask for assistance because of his/her cognition.</p> <p>The facility failed to provide interventions and monitoring to keep the resident free of falls.</p> | F 323  |  |                            |  |